Department of Veterans Affairs Community Living Center Survey Report

This document or report and the information contained herein, which resulted from the Community Living Center Unannounced Survey, has been de-identified to remove individually identifiable health information (also known as protected health information) in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule and other federal and state laws. De-Identification was completed in accordance with guidance published by the Office for Civil Rights to protect the privacy of the Community Living Center's residents.

General Information:

CLC: Edward Hines Jr. VA Medical Center (Hines, IL)

Dates of Survey: 8/14/2018 to 8/16/2018

Total Available Beds: 175

Census on First Day of Survey: 118

F-Tag	Findings
F166 483.10(f)(2) *A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.* **Level of Harm** - No actual harm with potential for more than minimal harm that is not immediate jeopardy **Residents Affected** - Few	Based on interview and record review, the CLC did not ensure there were prompt efforts to resolve resident grievances. Findings include: The CLC's policy titled, "Resolving Veteran Complaints – Attachment A," and dated 10/02/13 was provided by a quality manager on 08/14/18 at 3:26 p.m. The policy/procedure indicated, "Resolving Veteran Complaints – When patients complain, it is often because they have experienced what they consider to be a serious problem. After complaining, they expect timely action and a fair outcome. Outcomes are tailored to the individual situation and Veteran. This may include one and/or all of the following: • A sincere apology – most patients would like to hear acknowledgement of error personally from a member of the staff when there is a system/service failure. • Urgency – Demonstrating action to resolve the problem immediately sends a message to the patient that their care is a priority to the organization. • Empathy – Letting the patient know that the organization cares and feelings are understood…. • Refer – Refer appropriate consumer concerns to the Patient Advocate for 'comp' – ing (VA Canteen Certificate)." The CLC's policy dated 05/04/18 and titled, "Management of Patients' Personal Effects," was provided by the quality manager on 08/16/18 at 7:44 a.m. The policy/procedure indicated, "Environmental Management Service will conduct semi-annual audits of patients' effects and valuables" and "Nursing personnel will oversee the welfare of patients' effects in unit [neighborhood] situations. This includes advising patients or their representatives of their risk of poor security habits, collecting, inventorying, and arranging transfers of patients' effects to other authorized personnel and verification of exchange of patients' effects to authorized personnel." Resident #107, [LOCATION] • During an interview on 08/14/18 at 2:05 p.m., Resident #107 from [LOCATION] stated the CLC "has yearly cleaning; they [CLC staff] took everything out of my room and placed it in the hallway. A whole drawer of my stuff was missing; it happened a couple of months ago. I wasn't here when they took the stuff out of my room." When asked if he reported the missing items to CLC staff, the resident stated, "Yes, I reported it to [nurse manager]." When asked if the resident received a response from the nurse manager, the resident stated, "She [nurse manager] said, 'Good, you have too much stuff.'" The resident indicated he brought up the missing items at a Resident Council meeting and reported it again to the nurse manager. The resident said, "I had a picture of my great grandparents from Ireland and some Ziploc bags for fruits and vegetables. It was like the [nurse manager] put it on me [to figure out what happened to the personal belongings]. I did not make out a police report." The resident indicated he did not complete a police report because he felt this was a staff responsibility (to file the police report). The resident showed the surveyor items currently in his room and stated,

"I have been here for a long time; they [staff] are going to clean my room again." Although the room did not appear excessively cluttered, the resident had personal items on the floor along the wall on the right side of his bed. The resident did not have a roommate.

- During an interview on 08/15/18 at 5:59 p.m., with the resident's permission, the resident's concerns were shared with the nurse manager of [LOCATION] The nurse manager stated, "[Resident #107] is like a hoarder. He has too much stuff in his room. [Resident #107's] belongings were moved into the hall to clean his room. I don't know what else to do. He was blaming [staff] that they took his things. He [does not] think he has too much in his room. He had 20 pair of shoes in his room. I told him to report it [the missing items] to the police so he could be reimbursed." The nurse manager stated, "EMS [environmental management services] staff are not allowed to touch the resident's personal items when cleaning the resident's room. Nursing staff [nursing assistants] can move it [resident's personal belongings]." It was indicated there was no documentation of the resident's concerns regarding the missing items or follow-up to the concerns. Staff had not assisted the resident to search the room to locate the missing items.
- During an interview on 08/16/18 at 8:45 a.m., Resident #107 stated, "She [nurse manager] talked to me earlier and thought I was accusing staff of taking my things. I told her another resident said he saw someone walking down the hall with my items but wasn't sure who it was. I did not [originally] tell her about my great grandparent's picture because I didn't realize the picture was missing until later." When asked by the surveyor if the picture was in the drawer from which items were reportedly missing, the resident stated, "It was hanging on the wall. They [staff] removed everything off the wall and the floor for terminal cleaning."
- During an interview on 08/16/18 at 9:00 a.m., the nurse manager stated, "He [resident] didn't tell me about his great grandparent's picture [when the missing items were originally reported]; he only mentioned plastic bags and a knife was missing from his drawer. I thought he was blaming my staff of taking his things." The nurse manager did not indicate what would be done to locate the resident's items. The nurse manager indicated resident rooms were terminally cleaned twice a year and did not mention a plan to prevent future occurrences of missing items.
- During the daily meeting on 08/15/18 at 3:30 p.m., CLC leadership staff was informed about Resident #107's missing personal items resulting from CLC staff removing the items from the resident's room for terminal cleaning of the room; no additional information was provided by the staff.
- In summary, it was not evident CLC staff provided a "sincere apology," demonstrated urgency to resolve the resident's concerns, showed empathy and referred the resident to the Patient Advocate as indicated in the CLC policy when the resident indicated he had items that were missing. Staff did not assist the resident to notify the police about the missing items or assist to search for the missing items including the picture, after learning the items were missing.

F241

483.15(a) *Dignity. The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.*

Level of Harm - No actual harm with potential for more than minimal harm that is not immediate jeopardy

Residents Affected - Few

Based on observation, interview and record review, the CLC did not promote care for residents in a manner and in an environment that maintained or enhanced each resident's dignity. Findings include:

The CLC's resident handbook titled, "Rights and Responsibilities of VA Patients and Residents of Community Living Centers (CLC)," and dated 01/15/13 was provided by a quality manager on 08/14/18 at 3:05 p.m. The resident handbook indicated, "Additional Rights and Responsibilities of Community Living Center Residents: Staff will knock on your bedroom door prior to entry."

Resident #205, [LOCATION]

- Resident #205 was admitted to the CLC on [DATE], with diagnoses including prostate adenocarcinoma metastases to bone; the resident was receiving hospice care. According to the quarterly Minimum Data Set (MDS) dated 06/24/18 the resident had clear speech, and understood and was understood by others. The resident had a Brief Interview for Mental Status (BIMS) score of 15 suggesting intact cognition.
- The resident's care plan dated 08/14/18 stated, "Problem: Spiritual needs; Resident…prefers not to be disturbed during prayers. Approach: Please schedule care according to prayer time outlined on Salat timings for Greater Chicago Area. Please allow veteran privacy during these times." The prayer times were to occur five times a day (dawn, midday, late part of the afternoon, just after sunset, between sunset and

midnight) and varied depending on the day; a schedule of the prayer times was available at the nursing station.
- On 08/14/18 at 4:50 p.m., the RN stated (as she went by the resident's room with the door closed), "I cannot go in their because the resident is doing his prayers and does not like to be disturbed." At 4:58 p.m., a dietary assistant knocked on the resident's door and entered without a response from the resident.
- On 08/15/18 at approximately 2:30 p.m., the resident was interviewed and stated, "The staff come in frequently without knocking or without waiting for me to respond." The resident stated he followed a prayer schedule and did not want to be disturbed during the prayer times.

Resident #101, [LOCATION]

- Resident #101 was admitted to the CLC on [DATE] and most recently admitted on [DATE] with diagnoses including quadriplegia and TBI (traumatic brain injury) with loss of consciousness. The resident's admission MDS dated [DATE] and quarterly MDS dated 06/16/18 were coded to indicate the resident had clear speech, and understood and was understood by others; the resident had a BIMS score of 15 suggesting intact cognition. According to the MDS the resident required total assistance with activities of daily living.
- During an interview on 08/14/18 at 1:03 p.m., when asked by the surveyor if staff knocked before entering the resident's room, Resident #101 stated, "Staff that work here knock but staff from other departments, from food and nutrition, housekeeping, volunteers and newer staff do not. Some will knock, but many times won't wait for a response before entering the room."

F279

483.20(k) *Comprehensive Care Plans. (1) The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following: (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and (ii) Any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).*

Level of Harm - No actual harm with potential for more than minimal harm that is not immediate jeopardy

Residents Affected - Few

Based on observation, interview and record review, the CLC did not develop a comprehensive care plan for each resident that included measurable objectives and timetable to meet a resident's medical, nursing, and mental and psychosocial needs. Findings include:

Resident #304, [LOCATION]

- Resident #304 was admitted to the CLC on [DATE] with diagnoses including right below knee amputation (BKA), peripheral vascular disease (PVD), and osteomyelitis. The resident's admission history and physical dated [DATE] stated, "Transferred from medical unit [LOCATION] earlier today. However upon hearing that he was going to have a roommate he stated he would kill his roommate….For safety of nursing staff and roommate, he was moved to a single [private] room."
- The resident's admission MDS dated [DATE] was coded to indicate the resident had a Brief Interview for Mental Status (BIMS) score of 15 suggesting intact cognition. The MDS indicated the resident experienced behavioral symptoms of potential distress including verbal behavioral symptoms directed toward others that placed others at significant risk for physical injury, significantly intruded on the privacy or activity of others, and significantly disrupted care or the living environment. The Care Area Assessment (CAA) summary completed in conjunction with the MDS dated [DATE] stated, "Resident is immediate threat to others – Immediate Intervention Required." The resident's quarterly MDS dated 06/26/18 was coded to indicate the resident had a Brief Interview for Mental Status (BIMS) score of 15 suggesting intact cognition and did not experience behavioral symptoms of potential distress. Although the quarterly MDS indicated the resident did not experience behavioral symptoms, staff indicated during interview the resident continued to experience behavioral symptoms (since admission).
- During the initial tour on 08/14/18 at 11:00 a.m., an RN stated, "[Resident #304] is verbally abusive to all, refuses care. He is here for [a non-healing] left leg wound."
- The resident's care plan dated 04/10/18 included a statement addressing Mood with approaches that read, "Give antidepressant meds [medications] as ordered, monitor for side effects, maintain fall precautions, mental health is following. Have offered supportive therapy. Resident #304 has declined MH [mental health] will continue to encourage to participate." A care plan was not developed to address the resident's behavioral symptoms (e.g., refusing care, cursing at other residents).
- A recreational therapy note dated 07/08/18 indicated, "Resident [#304] became upset when another resident had multiple bingo cards out on the table and [Resident #304] started cursing at other resident."
- A nursing note dated 07/29/18 stated, "Another vet [Veteran who was another resident of the CLC] came to the nurse's station to report an event between himself and [Resident #304]. Per another vet he was smoking his cigar outside near the flags when [Resident #304] told him [the other resident] 'Get the hell out of here, this is my area.'

Per other resident [Resident #304] also grabbed one of his cigars and broke it in half….Instructed other resident to stay away from [Resident #304] and report if there were any other incidences."

- Although requested, the resident declined to participate in an interview with the surveyor. The resident was not otherwise observed in the CLC during the survey.
- During an interview with the medical director on 08/16/18 at 9:20 a.m., the medical director indicated a coordinated clinical review board (CCRB) was requested on 08/10/18. The written request was provided by a performance improvement specialist; the request stated, "Reason for request….Chronic history of non-compliance [non-compliant] behavior disruption at acute care setting and ECC [extended care center]. (1) Non-compliant with nursing care, wound care, medication intake. (2) Refusing insulin multiple times and fingerstick with resultant uncontrolled BS [blood sugars]. (3) Behavior problems and lack of respect to nursing staff and ECC residents. (4) Aggressive behaviors to at least one resident reported by the recreation therapist." When asked for a plan that was in place prior to the CCRB, the medical director indicated, "There is no plan."
- On 08/16/18 at 10:00 a.m., the performance improvement specialist provided a written list of interventions to be implemented to address the resident's behavioral symptoms; the list was developed after surveyor discussions with staff. The staff that developed the list included (but not limited to) the chief nurse manager of [LOCATION], chief nurse of geriatrics and extended care (GEC), psychiatrist, geriatric provider, Veterans Integrated Service Network (VISN) GEC lead, and performance improvement specialist. The list included interventions that were reportedly effective and to be implemented to address Resident #304's behavioral symptoms; the staff indicated the interventions were not documented in the resident's medical record or plan of care. The list included (but were not limited to) the following:
    - "Placed resident in a private room.
    - No male caregiver per his request.
    - [Resident] Allowed Bluetooth speaker for music on phone.
    - Asked to let us [CLC staff] know when leaves and returns to unit [neighborhood].
    - Asked other residents to let nurses know if being bothered.
    - Stopped going to bingo so RT [recreational therapy] offering 1:1 [one-to-one] activities but [he] refused. Leave food tray at nurses' station.
    - Frequent interaction/discussion [with] CNM [chief nurse manager].
    - Multiple staff reassignments to meet his requests.
    - Prevention & management of disruptive behavior (PMDB) staff training every two years."
- In summary, staff indicated Resident #304 continued to experience behavioral symptoms (since admission) including verbal and "aggressive" behavioral symptoms directed toward other residents and staff. For example, a nursing note dated 07/29/18 stated, "Another vet [Veteran who was another resident of the CLC] came to the nurse's station to report…he was smoking his cigar outside near the flags when [Resident #304] told him [the other resident] 'Get the hell out of here, this is my area.' Per other resident, [Resident #304] also grabbed one of his cigars and broke it in half….Instructed other resident to stay away from [Resident #304] and report if there were any other incidences." A request was made for a CCRB on 08/10/18; when a plan was requested to address the resident's behavioral symptoms, the medical director stated, "There is no plan." On 08/16/18 following discussions with surveyors regarding the resident's behavioral symptoms, a list of approaches was provided; the staff that provided the plan indicated the approaches and interventions were not documented including on the resident's plan of care.

F323

483.25(h)(2) *The facility must ensure that: Each resident receives adequate supervision and assistance devices to prevent accidents.*

Level of Harm - No actual harm with potential for more than minimal harm that is not immediate jeopardy

Residents Affected - Few

Based on observation, interview and clinical record review, the CLC did not ensure that residents received adequate supervision to prevent accidents and the environment remained as free of accident hazards as possible. Findings include:

The CLC's policy titled, "VA Hospital Hines, IL [Illinois] 60141 Policy Memorandum 578-06-126-002 (R-2) Evaluation and Management of Swallowing and Feeding Disorders," dated April 1, 2015, was provided by the performance improvement (PI) specialist of geriatrics and extended care (GEC) on 08/16/18 at 7:45 a.m. The policy indicated:

- "3. Responsibilities a. The Chief of Staff and the Associate Director/Patient Care Services are responsible for….(2) Ensuring effective interdisciplinary collaboration among those involved in the care of patients with swallowing and feeding disorders….(4) Ensuring that clinical staff and managers understand and adhere to

their responsibilities under this policy;"

- "c. Associate Chief of Nursing Service (ACNS) is responsible for: (1) Assuring that orientation and education on assessment, support, provision and documentation of swallowing, feeding, and oral care are provided; (2) Overseeing and monitoring the nursing components of this policy;"
- "d. The Registered Nurse (RN) is responsible for….(6) Supervising meals and supplemental feedings and providing assistance when appropriate;"
- "e. Speech Language Pathologists (SLP) are responsible for….(4) After completion of the swallowing evaluation, updating the CPRS [computerized patient record system] Problem List to include dysphagia for any patient diagnosed with such and entering into the Clinical Warning Advanced Directive (CWAD) any patient who is determined to exhibit a significant risk for aspiration and/or airway obstruction; (5) Following up on swallowing consult recommendations with appropriate management and treatment by working in consultation with other members of the care team to develop an appropriate, customized, patient and family-centered plan of care (treatment plan);"
- 4. Action….c. Evaluation of, and intervention for swallowing and feeding disorders (upon receipt of a consult)….(4) Provide education to the resident/patient, family, and staff on the results of swallowing assessment and plans for intervention, where appropriate, and document same in CPRS. (5)….Dietary consistency guidelines and swallowing compensations will be posted in the resident/patient's room in concert with the JCAHO privacy guidelines."

Resident #305, [LOCATION]

- Resident #305 was admitted to the CLC on [DATE] with diagnoses including cerebrovascular accident (CVA) with residual left-sided weakness, dementia, and dysphagia. The resident's admission MDS dated [DATE] was coded to indicate the resident had a Brief Interview for Mental Status (BIMS) score of 10 suggesting moderately impaired cognition, was totally dependent on staff for eating, and had signs and symptoms of a possible swallowing disorder including coughing or choking during meals or when swallowing medication. The MDS indicated the resident was to receive a therapeutic and mechanically altered diet.
- During the initial tour on 08/14/18 at 11:00 a.m., an RN stated, "He [Resident #305] is confused….he is on a puree, nectar thick liquid diet…he has a special straw he doesn't always use."
- The resident's care plan dated 06/28/18 included a statement addressing, "Chronic disease related severe malnutrition r/t [related to] inadequate protein – energy intake and increased nutrient demands….The following approaches were listed: "Diet Rx [prescription]: Dysphasia 1 (Pureed) Nectar Thick Liquids via teaspoon or w/ [with] safe, bolus-limiting straw….Monitor po [oral] intake/diet tolerance at meal round observations. Monitor for s/s [signs and symptoms] swallowing difficulty and alert RD [registered dietitian] and SLP [speech-language pathologist] as indicated….Provide 1:1 [one-to-one] assistance at meals and snacks." Specific swallowing precautions as indicated in the swallowing management discharge note dated [DATE] (below) were not addressed in the care plan.
- A provider's order dated 06/15/18 stated, "Dys[phagia] 1 pureed thick liquid nectar."
- A swallowing management discharge note dated [DATE] indicated, "Assessment: Pt [patient] with h/o [history of] moderate-severe oropharyngeal dysphagia requiring modification and swallow precautions….Reviewed swallow precautions with RN. SLP [speech-language pathologist] to sign off at this time as resident reportedly refused to fully cooperate for full clinical assessment, although appears to be tolerating current diet, to this date, given strict adherence to prescribed swallow precautions as detailed below.
    - 1. Dysphagia 1 (puree) bolus – limiting straw use….1:1 [one-to-one] assist[ance] for PO [oral] presentation and adherence to below precautions.
    - 2. Liquids: Nectar thick via single spoonful or bolus limiting straw.
    - 3. Strict aspiration precautions: *CUE RESIDENT TO COMPLETE THE LISTED PRECAUTIONS ACROSS ALL PO INTAKE! *FEED SLOWLY IN SMALL BITES. *CHECK ORAL CAVITY AFTER ALL PO INTAKE *MAKE SURE RESIDENT HAS SWALLOWED AND CLEARED ORAL RESIDUE BEFORE PRESENTING NEXT BITE [emphasis not added]. *Cue resident to complete an additional dry swallow after every bite and sip. *Cue resident to swallow frequently as resident with tendency to bolus hold particular to puree…. Swallow precaution sign posted with resident consent: Yes."
- An undated, orange sign with the swallowing precautions addressed in the swallowing management discharge noted dated [DATE] was observed on the corkboard on the wall next to the resident's bed; the sign had been posted with the resident's permission.

- During an observation on 08/14/18 at 5:35 p.m. Resident #305 was served pureed mostaccioli, broccoli and peaches; and a nectar-thick Mighty Shake® (nutritional supplement) and nectar-thick juice. The resident was provided 1:1 assistance but was not cued to dry swallow between bites. The resident coughed briefly five times while consuming the mostaccioli; the resident was not observed with other signs or symptoms of aspiration (e.g., teary eyes, runny nose). The NA asked the resident after each cough if the resident was okay and then provided additional heaping spoonfuls of food. The resident used a bolus-limiting straw with fluids during this observation.
- During an observation on 08/15/18 at 5:30 p.m., Resident #305 was served pureed chicken and dumplings, pureed carrots, chocolate pudding, a nectar-thick Mighty Shake, nectar-thick coffee, and nectar-thick apple juice. The resident was provided 1:1 assistance with the meal. The same NA observed on 08/14/18 presented the resident with heaping spoonfuls of the pureed food; the resident was not directed to dry swallow between bites. On four occasions the resident had visible food in the cheeks when the next spoonful was offered. The resident coughed briefly once during the observation; the resident was not observed with other signs or symptoms of aspiration (e.g., teary eyes, runny nose). The resident requested the bolus-controlled straw since the straw was not on the tray; the NA stated, “Sometimes they [nutrition and food service staff] don’t send it.” The resident was spoon fed the liquids without concerns observed.
- During an interview on 08/15/18 at 5:00 p.m. with the NA that assisted the resident to eat during both observations, the NA stated, “I cue him [Resident #305]; he pockets a lot so I wait for him to swallow. He does cough a lot [while consuming] with liquids and solids.” When asked if the resident had any aspiration precautions, the NA replied, “I’m not aware of any swallowing precautions.”
- During an interview on 08/16/18 at 8:00 a.m. with the supervisor of the speech department, the supervisor stated, “We can be better at educating staff on swallowing precautions, we focus on RNs and not NAs.” The supervisor indicated that NAs would be included in future in-service education.
- In summary, during observations of meals on 08/14/18 and 08/15/18, Resident #305 was served a diet as ordered; however, staff did not follow swallowing precautions as indicated in the swallowing management discharge note dated [DATE]. The resident was provided 1:1 assistance but was not cued to dry swallow between bites. During the meal on 08/14/18, the resident coughed briefly five times while consuming the mostaccioli; the resident was not observed with other signs or symptoms of aspiration (e.g., teary eyes, runny nose). The NA asked the resident after each cough if the resident was okay and then provided additional heaping spoonfuls of food. The resident used a bolus-limiting straw with fluids during this observation. On 08/15/18 at 5:30 p.m., Resident #305 was served the diet as ordered. The resident was provided 1:1 assistance but was not cued to dry swallow between bites. The same NA observed on 08/14/18 presented the resident with heaping spoonfuls of the pureed food. On four occasions the resident had visible food in the cheeks when the next spoonful was offered. The resident coughed briefly once during the observation; the resident was not observed with other signs or symptoms of aspiration (e.g., teary eyes, runny nose). Although the bolus-controlled straw was not provided, the resident was spoon fed the liquids without concerns observed; it was indicated the bolus-controlled straw was not always provided on the resident’s meal tray. The NA that assisted the resident to eat was not aware of the resident’s swallowing precautions. The CLC did not consistently implement the swallowing precautions.

F441

483.65 *Infection Control. The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection.*

Level of Harm - No actual harm with potential for more than minimal harm that is not immediate jeopardy

Based on observation, interview and record review, the CLC did not maintain an infection prevention and control program designed to help prevent the development and transmission of disease and infection. Findings include:

The CLC’s policy dated January 4, 2017 and titled, “VA Hospital Hines, IL [Illinois] 60141 Policy Memorandum 578-02-011-034(r-4) Isolation/Precautions Categories,” was provided by the accreditation specialist on 08/15/18. The policy indicated, “a. Standard Precautions….(1) Hand hygiene will be performed before and after patient [resident] contact, after contact with an actually or potentially contaminated item, after inadvertent contact with blood, body fluids, secretions or excretions, and immediately after gloves are removed. Use of gloves is not a substitute for hand hygiene. It may be necessary to perform hand hygiene between tasks and procedures on the same resident to prevent cross contamination of different body sites….b. Transmission-Based Precautions….(2) Contact Precautions….(d) A green strip is placed or the door or door jamb of the room ….(e) At a minimum, all staff entering a room under contact

Residents Affected - Some

precautions will wear gloves and gowns. A fluid-impervious gown is required if significant exposure to body fluid is anticipated. Exception: Food Service workers delivering trays are not required to wear gowns. Food Service workers must perform hand hygiene (either with waterless hand sanitizer or anti-bacterial soap/ water/ paper towel) upon entering the room to serve the tray to that resident. The Food Service worker must then use wax tissue (one per hand) as a barrier to contact with the over-bed table when delivering….Hand hygiene must be performed immediately after leaving the resident's room.... d. If delivering to bedside, the tray passer must read the color coded sign on the door/color coded magnetic strip on the door frame to check for isolation type and instructions on whether entry into room is allowed."

Nursing Staff

[LOCATION]

- During observations on 08/14/18 at 4:12 p.m., the wound care nurse (WCN) was observed performing wound care for Resident #103 in [LOCATION]; a green strip was posted on the door jamb of the resident's room. The nurse performed hand hygiene, donned a gown and gloves, and entered the resident's room. The nurse did not perform hand hygiene after doffing and before donning gloves throughout the wound care procedure. After the WCN's gown and gloves came into contact with the resident's bed, the WCN was observed returning to the treatment cart parked in the doorway of the resident's room. The sleeve of the WCN's gown was observed to come into contact with the top of the treatment cart.

[LOCATION]

- During observations of medication administration on 08/15/18 at 8:47 a.m., an RN was observed by the quality manager (QM) and a surveyor administering inhalation, subcutaneous, and oral medications for Resident #106 in the resident's room on [LOCATION]. A green strip was posted on the door jamb of the resident's room. The nurse performed hand hygiene, donned a gown and gloves, and entered the resident's room. The RN's gown came into contact with the resident's bed and when the RN returned to the medication cart parked in the doorway of the resident's room, the sleeve of the RN's gown was observed to come into contact with the top of the medication cart.

Nutrition and Food Service (NFS) Staff

[LOCATION]

- On 08/15/18 at 12:30 p.m., a NFS staff person was observed bringing meal trays into resident rooms including one room with a green magnet on the door indicating staff was to implement Contact Precautions for the resident. The staff member did not perform hand hygiene and carried the meal tray into the resident's room; the NFS staff person did not use wax paper that was available on the top of the cart as a barrier and did not perform hand hygiene after leaving the resident's room.
- At 12:36 p.m., the NFS staff person was interviewed and stated, "I use my judgement about the blue and green signs [on the doors] but we are out of gloves." The staff person did not know wax paper was to be used as a barrier in rooms where Contact Precautions were to be implemented.

[LOCATION]

- During an interview on 08/15/18 at 12:25 p.m. with another NFS staff person passing trays in [LOCATION], the staff person stated, "We [NFS] only need to use the wax paper with doors that have a red marker on the outside of the door." The staff person was not observed entering rooms where Contact Precautions were required.

Environmental Management Services (EMS) Staff

[LOCATION]

- During an interview on 08/14/18 at 1:45 p.m. with a resident for whom staff was to implement Contact Precautions, an EMS staff member entered the residents room, and without donning gloves or a gown, leaned against the sink in the room to fix the paper towel dispenser. The EMS staff member was not observed performing hand hygiene with use of the sanitizer dispenser just outside the door to the room.